TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-16-2260-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
April 4, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This medication does not fall into any of the categories regarding preauthorization.

Amount in Dispute: $489.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In conclusion, no reimbursement should be awarded to Requestor for the compound medication as preauthorization was required because one of the ingredients is not included in the Division's drug formulary."

Response Submitted by: Downs ♦ Stanford, 2001 Bryan Street, Suite 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 22, 2015	Baclofen, Amantadine, Gavapentin, Amitriptyline, Bupivicaine	$489.96	$489.96

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.540 sets out the requirements for use of the closed formulary for claims subject to certified networks.
3. 28 Texas Administrative Code §134.503 sets out the pharmacy fee guidelines

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - 197 – Payment denied/reduced for absence of precertification/authorization
    - W3 – Additional payment made on appeal/reconsideration
    - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Is the carrier's denial supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier denied the services in dispute as 197 – "Payment denied/reduced for absence of precertification/authorization." Per 28 Texas Administrative Act §134.540(b) applies which states in pertinent part,

    Preauthorization for claims subject to the Division's closed formulary. Preauthorization is only required for:

    (1) drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;

    (2) any compound that contains a drug identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates; and

    (3) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

The service in dispute is a compound medication containing Baclofen, Amantadine HCL, Gabapentin USP, Amitriptyline HCL, Bupivicaine HCL.

Review of Appendix A, ODG Workers' Compensation Drug Formulary finds that the services in dispute were not listed as an "N" drug nor were they found to be investigational or experimental.

Pursuant to Rule 134.503(b)(1)(A) the Division concludes that preauthorization was not required for the service in dispute. For that reason, the division finds the carrier's preauthorization denial is not supported.

2. 28 Texas Administrative Code §134.503(c) states,

    The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

    (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:

    (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

    (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;

    (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection;

The maximum allowable reimbursement will be calculated as follows:

Date of Service	Service in Dispute	Units	Amount Billed	MAR
May 22, 2015	Baclofen Powder	5	$184.68	$35.63000 x 5 + $4.00 = $226.69

May 22, 2015	Amantadine HCL	3	$38.46	$24.22500 x 3 + $4.00 = $94.84
May 22, 2015	Gabapentin USP	4	$188.10	$59.85000 x 4 + $4.00 = $303.25
May 22, 2015	Amityiptyline HCL	2	$30.70	$18.24000 x 2 + $4.00 = $49.60
May 22, 2015	Bupivacaine HCL	1	$48.02	$45.6000 x 1 +4.00 = $61.00
			Total	$735.38

3. The total allowable for the services in dispute based on the submitted NDC numbers and quantity submitted is $735.38. The requestor is seeking $489.96. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $489.96.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $489.96 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		April , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.